



CIGNA HealthCare

**CIGNA HealthCare of
Arizona, Inc.
HMO**

This document takes the place of any documents previously
issued to you which described your benefits.



Thank you for choosing CIGNA HealthCare!

Here is your guide to getting the most from your health care plan.
It outlines the important benefits of belonging to a CIGNA HealthCare plan,
tells you how to use those benefits wisely and
should answer most of your questions.

Please keep it for reference.

If you can't find the information that you need,
call Member Services at
the toll-free number on your CIGNA HealthCare ID card.

Or visit our web site, www.cigna.com.

We're here to help!



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CIGNA HealthCare Handbook

The Benefits of Belonging to a CIGNA HealthCare Plan

Your CIGNA HealthCare plan is designed to help you stay healthy.

As you read through this information, you'll learn more about the covered services, benefits and special programs that help you take better care of yourself.

You choose a Primary Care Physician (PCP) to serve as your personal physician. Your PCP can treat you for a wide variety of conditions, provide preventive care, refer you to specialists and coordinate hospital care when needed. Each covered member of your family can choose his or her own PCP.

Your plan includes:

- Preventive Care – coverage for regular checkups, tests and childhood immunizations through programs tailored to your needs.
- As part of the CIGNA HealthCare's commitment to women's health, you can see an OB/GYN in the CIGNA HealthCare network for covered obstetrical and gynecological services without a referral from your PCP.
- Prenatal care once your pregnancy is confirmed. You pay only the copayment for the first office visit, the one that confirms you're pregnant. After that, you pay nothing for routine maternity office visits throughout your pregnancy.
- 24-hour emergency coverage, worldwide.
- **Access to the CIGNA HealthCare 24-Hour Health Information Line.SM** This line is staffed by Registered Nurses who can assist with health related questions at any time of the day or night. Look for the 24-Hour Health Information Line Library at the end of this guide.
- **Guest Privileges** – under certain circumstances, such as when you are temporarily away from your usual service area for at least 60 days, you may be able to obtain coverage in another area where there is a CIGNA HealthCare plan available.

- **Working Wonders[®]** to reward you for staying fit and active. Just call 1.800.811.1872 to learn more about the program.
- **CIGNA HealthCare Healthy Rewards,[®]** the CIGNA HealthCare program that gives you special offers for discounts on health-related products and services. To learn more, call 1.800.870.3470 or visit our Web site at www.cigna.com.

If You Have a Question

This Handbook briefly summarizes some of the important features of your coverage. For a complete explanation of your coverage please refer to your Group Service Agreement.

Where to Find More Information

CIGNA HealthCare offers you a variety of ways to learn more about your plan and coverage. We strive to make sure that the answers you need are always close by.

Your CIGNA HealthCare ID Card

Your CIGNA HealthCare identification (ID) card identifies you as a CIGNA HealthCare member to physicians, hospitals and other health care providers. Show it and you'll receive all of the service and supplies your plan offers as long as you are eligible.

- Carry it with you at all times.
- Show it whenever you receive medical care.
- If you lose your card or if it's stolen, just call 1-800-CIGNA24. We'll send you a replacement right away.
- Each family member covered by your plan, even your children, should have his or her own card. If you need additional cards for family members, just call Member Services.

Member Services

Member Services answers your questions, finds the information you need and works to resolve your problem quickly.

- The toll-free number is on your CIGNA HealthCare ID card.



- Se habla español – and most other languages. We have bilingual representatives in Spanish-speaking areas and the AT&T Language Line translates more than 140 other languages.

Call Member Services if:

- Any of your personal or family information changes – name, address, phone number, marital status, employment or number of dependents. Also notify your employer of these changes.
- You have questions about how your plan works, your benefits, or a claim.
- You'd like an updated Physician Directory or more detailed information about a doctor or hospital.
- You want to change your PCP.

www.cigna.com

Our interactive web site is a valuable source of information. We update it often, so visit it often! You can:

- Find participating physicians, specialists, hospitals, and pharmacies fast. Now available in most areas, our interactive directories do the work. You can also download and print customized directories, even change your PCP online.
- Learn more about your plan and the benefits and programs available to you and your covered family members.
- Visit **YourHealth@CIGNA®** to learn about important health care topics. Read online editions of our newsletter for helpful information on personal and family health, diet, exercise and healthy lifestyles.

The CIGNA HealthCare 24-Hour Health Information LineSM

No matter where in the U.S. you are, helpful health information is as close as the nearest phone. Just call the CIGNA HealthCare 24-Hour Health Information Line.SM The toll-free number is 1.800.564.8982. You can:

- Speak with registered nurses for answers to your health questions, including questions regarding

emergency or urgent care, and get self-care tips that can help ease the discomfort of an illness or injury.

- Listen to informative, recorded programs on more than 1,000 health topics. The Health Information Library program list is at the end of this guide.
- Listen to as many programs as you like, whenever you like. And you can control all of the playback functions with your phone.

This service is available around the clock, seven days a week.

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Emergencies

An emergency is a sudden unexpected injury or a serious illness that a prudent layperson (a person with an average knowledge of medical science) believes needs to be treated right away or it could result in serious medical complications or permanent impairment. For more information about emergency care, please see "Section IV" in the Group Service Agreement.

What to do in an emergency:

- Don't delay! Get help immediately. Call or ask someone to call 911 or your local emergency service, police or fire department. Or go directly to the nearest emergency facility.
- In an emergency you can go to any emergency facility or hospital, anywhere, even one that is not in the CIGNA HealthCare network.
- You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.
- You're covered 24 hours a day, seven days a week.
- You will pay only a copayment for covered emergency services; it may be higher than your office visit copayment and is listed on your CIGNA HealthCare of New Hampshire, Inc. ID card.



- If you are unsure about whether you should seek emergency care you can call your PCP, the physician covering calls for your PCP or the CIGNA HealthCare 24-Hour Health Information Line.SM

Examples of emergency situations can include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or severe squeezing sensation in the chest
- Suspected overdose of medication or poisoning
- Sudden paralysis or slurred speech
- Burns
- Cuts
- Broken bones

Urgent Care

You're also covered for situations that aren't emergencies but still require prompt medical attention. Examples can include:

- Severe sore throat
- Sprains and strains
- Ear or eye infection
- Fever in an adult or child

What to do when you need urgent care:

- If possible, call your PCP first. This notifies your doctor of your condition and helps coordinate your care for effective treatment.
- You can also call the CIGNA HealthCare 24-Hour Health Information LineSM and ask to speak with a registered nurse about your condition.

Your PCP or the CIGNA HealthCare 24-Hour Health Information Line nurse may recommend steps you can take to be more comfortable and/or schedule an office visit.

Other Medical Care

Situations that are not considered emergencies or do not require urgent care should be handled through a scheduled office visit with your PCP. Examples can include:

- Routine physicals
- Childhood immunizations
- Routine care for chronic conditions
- Follow-up visits to check injuries or broken bones
- Prescription drug needs

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Maricopa 01/03



Advance Directives

Your Right to Make Health Care Decisions Under the Law in Arizona

The following explains your right to make health care decisions and explains how “Advance Directives” can help you plan what medical care you want when you are unable to express your wishes.

We hope that what you read here will help you understand how you can increase your control over your medical treatment.

This information is sent to all adult members of CIGNA HealthCare in compliance with the Patient Self-Determination Act (PSDA) of 1990 enacted by Congress and effective December 1991. It is part of CIGNA’s ongoing community education on health care and member’s rights.

If you have any questions about material in this brochure, it is suggested that you discuss them with your physician, medical social worker, or call CIGNA HealthCare’s Member Services Department.

Arizona and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand, the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital’s medical staff to know what your specific wishes are about the medical care that you want or do not want to receive.

The following describes what Arizona and federal law have to say about your rights to inform your health care providers about medical care and treatment you want, or do not want, and about your right to select another person to make these decisions for you, if you are physically or mentally unable to make them yourself.

To make these difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is an important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and your attorney before deciding whether or not you want an advance directive.

General Information About Advance Directives

Q. What are “Advance Directives”?

A. Advance directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called “advance” directives, because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

Arizona law recognizes 4 types of advance directives:

- 1) A Living Will.
- 2) A Health Care Power of Attorney.
- 3) A Mental Health Care Power of Attorney.
- 4) A Pre-hospital Medical Care Directive.



Q. Do I have to have an Advance Directive?

- A.** No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under Arizona law, no health care provider or insurer can charge a different fee or rate depending on whether or not you have executed an advance directive.

Q. What will happen if I do not make an Advance Directive?

- A.** You will receive medical care even if you do not have any advance directives. However, there is a greater chance that you will receive more treatment or more procedures than you may want.

If you cannot speak for yourself and you do not have any advance directives, your doctor or other health care providers will look to the following people in the order listed for decisions about your care:

- 1) Your guardian, if a court has appointed one, who is authorized to make health care decisions for you;
- 2) Your spouse;
- 3) An adult child, or if you have more than one adult child, a majority of those children who are reasonably available for consultation;
- 4) Either of your parents;
- 5) Your domestic partner, if you are unmarried and no other person has assumed financial responsibility for you;
- 6) An adult brother or sister, or if you have more than one, a majority of those who are reasonably available for consultation;
- 7) A close friend of yours.

Q. How do I know what treatment I want?

- A.** Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best.

Your doctor can tell you the treatments that are available to you, but he cannot choose for you. That choice depends on what is important to you.

Q. Whom should I talk to about Advance Directives?

- A.** Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care, if you are unable to make your own decisions.

Q. When do Advance Directives go into effect?

- A.** It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give “informed consent,” your health care providers will rely on YOU and NOT on your advance directives.

Q. What is “Informed Consent”?

- A.** Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures AND you are able to communicate that understanding in any way.



Q. How will health care providers know if I have any Advance Directives?

- A.** All hospitals, nursing homes, home health agencies, HMOs and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

Q. Will my Advance Directives be followed?

- A.** Generally, yes, if they comply with Arizona law. Federal law requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with Arizona law. If this happens, they must immediately tell you. Then they must help you transfer to another doctor or facility that will do what you want.

Q. Can I change my mind after I write an Advance Directive?

- A.** Yes, at any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your revised documents to all the appropriate parties, including your doctor.

Q. Do I need a lawyer to help me make an Advance Directive?

- A.** A lawyer may be helpful and you might choose to discuss these matters with him, but there is no legal requirement in Arizona to do so.

Q. Will my Arizona Advance Directive(s) be honored in another state?

- A.** The laws on advance directives differ from state to state, so it is unclear whether an Arizona

advance directive will be honored in another state. Because an advance directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you should consider signing an advance directive that meets all the legal requirements of that state.

Q. Will an Advance Directive from another state be honored in Arizona?

- A.** Yes. An advance directive executed in compliance with another state's laws will be honored in Arizona to the extent permitted by Arizona law.

Q. What should I do with my Advance Directives?

- A.** You should keep them in a safe place where your family members can get to them. Do NOT keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergy person; and any local hospital or nursing home where you may be residing. Another idea is to keep a wallet card in your purse or wallet which states that you have an advance directive and who should be contacted.

Living Will

Q. What is a "Living Will"?

- A.** A living will is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal condition or if you are in a persistent vegetative state. It is called a "living will" because it takes effect while you are still living.

Q. Is a "Living Will" the same as a "Will" or "Living Trust"?

- A.** No. Wills and living trusts are financial documents which allow you to plan for the



distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete your Arizona living will.

Q. When does an Arizona Living Will go into effect?

- A.** An Arizona living will goes into effect when:
- 1) Your doctor has a copy of it, and
 - 2) Your doctor has concluded that you are able to make your own health care decisions, and
 - 3) Your doctor has determined that you are terminally ill or that you in a persistent vegetative state.

Q. What are “life-sustaining” treatments?

- A.** These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes, and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

Q. What is a “terminal” condition?

- A.** A terminal condition is defined as an incurable condition for which administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will occur in a relatively short period of time.

Q. What is a “persistent vegetative” state?

- A.** A persistent vegetative state means that a patient is in a permanent coma or state of unconsciousness caused by illness, injury or disease. The patient is totally unaware of himself, his surroundings and environment, and to a reasonable degree of medical certainty, there can be no recovery.

Q. Is a Living Will the same as a “Do Not Resuscitate (DNR)” order?

- A.** No. An Arizona living will covers almost all types of life-sustaining treatments and procedures. A “Do Not Resuscitate” order covers two types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

Q. Will I receive medication for pain?

- A.** Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Q. Can my doctor be sued or prosecuted for carrying out the provisions of an Arizona Living Will?

- A.** No. The Arizona Living Wills and Health Care Directives Act states that any health care provider who makes good faith decisions based on an apparently genuine health care directive is immune from criminal and civil liability and is not subject to any professional discipline.

Q. Does a Arizona Living Will affect insurance?

- A.** No. The making of a living will, in accordance with Arizona law, will not affect the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal of life-support systems according to Arizona law, shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of insurance coverage.

Q. Does an Arizona Living Will have to be signed and witnessed?

- A.** Yes, you must sign (or have someone sign the document in your presence and at your



direction, if you are unable to sign) and date the living will. Then it must be witnessed by 1 or 2 qualified adult people or notarized.

- 1) If you are able to have 2 witnesses sign the living will, neither of them may be your treating health care provider or an employee of your treating health care provider.
- 2) If only one witness signs the living will, he/she may not be your treating healthcare provider, an employee of your treating health care provider, related to you by blood, marriage or adoption, or entitled to any part of your estate upon your death.

Health Care Power of Attorney

Q. What is a Health Care Power of Attorney? (HPOA)

- A.** A HPOA is a legal document which allows you (the “principal”) to appoint another person (the “attorney-in-fact” or “agent”) to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

Q. Who can I select to be my Agent?

- A.** You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

Members of your family, such as your spouse, child, brother or sister, or even a close friend are usually good choices to be your agent.

Arizona law does not place any restrictions on who you can appoint as your agent. However, it is usually not a good idea to appoint your treating doctor, his/her employees, the owner or operator of a health care facility in which you

are a resident or any of his or her employees. This is due to a possible conflict of interest between being your agent and having a direct bearing on the kind of health care you will or will not receive.

Q. When does the HPOA take effect?

- A.** The HPOA only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making your decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make treatment decisions, you have the right to do so.

Q. What decisions can my Agent make?

- A.** Unless you limit his/her authority in the HPOA, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his/her duties. These decisions can include authorizing, refusing or withdrawing treatment, even if it means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

Q. Can there be more than one Agent?

- A.** Yes. While you are not required to do so, you may designate alternates who may also act for you, if your primary agent is unavailable, unable or unwilling to act. Your alternates have the same decision-making powers as the primary agent.

Q. Does the HPOA have to be signed and witnessed?

- A.** Yes, you must sign (or have someone sign the HPOA in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 1 or 2 qualified adults or notarized.



- 1) If you are able to have 2 witnesses sign the HPOA, neither of them may be the agent(s) that you appointed in the HPOA, your treating health care provider, or an employee of your treating health care provider.
- 2) If only one witness signs the HPOA, he/she may not be the agent(s) you appointed in the HPOA, your treating health care provider, an employee of your treating health care provider, related to you by blood, marriage or adoption, or be entitled to any part of your estate upon your death.

Mental Health Care Power of Attorney

Q. What is a Mental Health Care Power of Attorney (MHCPA)?

- A.** A MHCPA is a legal document which allows you (the “principal”) to appoint another person (the “attorney-in-fact” or “agent”) to make mental health care decisions for you, if you are no longer able to make those decisions yourself. It is very similar to the HPOA, but the MHCPA ONLY deals with mental health care.

Q. When does the MHCPA take effect?

- A.** The MHCPA only becomes effective when you are temporarily or permanently unable to make your own mental health care decisions and your agent consents to start making your decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make mental health care decisions, you have the right to do so.

Q. Who can I select to be my Agent?

- A.** You can appoint almost any adult person to be your agent. You should select a person knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about mental health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

Members of your family, such as your spouse, child, brother or sister, or even a close friend are usually good choices to be your agent.

The only person who CANNOT be appointed as your agent in the MHCPA is anyone who is directly involved with the provision of health care to you (i.e. your doctor or an administrator of a health care facility in which you are residing).

Q. Where can I get the MHCPA form?

- A.** You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send \$2.00 and a self addressed envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document (available in English only) will be mailed to you.

Q. Does the MHCPA have to be signed and witnessed?

- A.** Yes, you must sign (or have someone sign the MHCPA in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 1 or 2 qualified adults or notarized.

The following people CANNOT witness your signature of the MHCPA:

- 1) If you are able to have 2 witnesses sign the MHCPA, neither of them may be a person able to make medical decisions on your behalf or a professional care provider directly involved with the provision of care to you.
- 2) If only 1 witness signs the MCHPA, he or she may not be a person able to make medical decisions on your behalf, a professional care provider directly involved with the provision of care to you; related to you by blood, marriage or adoption, or be entitled to any part of your estate upon your death.



Prehospital Medical Care Directive

Q. What is a “Pre-hospital Medical Care Directive?”

- A.** A Pre-hospital Medical Care Directive is a document prepared by you to tell emergency personnel that you do not want cardiopulmonary resuscitation (CPR) performed should you suffer cardiac or respiratory arrest in an emergency situation or in an emergency room.

Q. Does the Directive have to be signed and witnessed?

- A.** Yes, you must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by one individual AND signed by your doctor.

Q. Where can I get the Pre-hospital Medical Care Directive Form?

- A.** You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send \$1.00 and a self addressed envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document (available in English only) will be mailed to you.

CIGNA HealthCare of Arizona, Inc. Policy on Advance Directives

CIGNA HealthCare of Arizona has a policy that complies with Arizona laws and court decisions on Advance Directives. CIGNA HealthCare is here to assist you in making these difficult decisions by supplying you with information to help you become an informed partner in your health care team.

CIGNA HealthCare shall document in your medical record whether or not you have executed an Advance Directive. For purposes of this policy, an Advance Directive means a written instruction that relates to the provision of health care when you are incapacitated, such as Durable Power of Attorney

for Health Care, a Declaration pursuant to the Natural Death Act, or a living will.

CIGNA HealthCare does not put conditions on providing care or otherwise discriminate against anyone based on whether or not that person has executed an *Advance Directive*. Please inform your Primary Care Physician if you have made an *Advance Directive*. At that time, you should also:

- provide a copy to your Primary Care Physician, and
- bring a copy with you when you check into a hospital or other health facility so that it can be readily available if needed.

It is CIGNA HealthCare policy that your wishes about treatment be followed whenever feasible. Should your doctor be unwilling to follow your directions, CIGNA HealthCare will assist in finding another physician or panel of physicians who will assume your care.

CIGNA HealthCare shall provide education to staff and the community on issues that concern *Advance Directives*.

Complaints concerning non-compliance with the *Advance Directive* requirements may be filed with the State survey and certification agency.

If you would like to either receive more information about Advance Directives or receive forms you can use to write a Living Will or Durable Power of Attorney, you may:

- Send \$3.95 to Professional Media Resources, P. O. Box 460380, St. Louis, MO 63146-7380. Please specify the state for which you need the forms.
- Or call Choice in Dying, 2009 Varick St., 10th Floor, New York, NY 10014 at 1 (800) 989-WILL.
- Or call Eldercare Location at 1 (800) 677-1116 to receive the name of the local agency that may be able to help you.
- Or write or call the American Association of Retired Persons, Legal Counsel for the Elderly, Inc., Attn: Lisa Parrott-Heath, P.O. Box 96474, Washington, D.C. 20090-6474, (202) 434-2117.



Sources of Information and Forms

The following organizations provide health care directive forms and information:

- Aging and Adult Administration
State of Arizona
1789 W. Jefferson, Site code 950A
Phoenix, Arizona 85007
(602) 542-4446
- Area Agency on Aging
Region One, Inc.
1366 E. Thomas Road, Suite 108
Phoenix, Arizona 85014
(602) 264-4357
- Dorothy Garske Center*
Your Health Care Choices Program
4250 E. Camelback Road, Suite 185K

Phoenix, Arizona 85018
(602) 952-1464

- Pima Council on Aging
5055 E. Broadway
Suite C104
Tucson, Arizona 85711
(520) 790-7262
- Office of Arizona Attorney General
Life Care Planning
Information & Documents
(602) 542-2124 phone
(602) 542-4377 fax
www.ag.state.az.us

*A Non-Profit Foundation, requesting fees or charitable donations for supplying directives.



GROUP SERVICE AGREEMENT





I. Definitions of Terms Used In this Group Service Agreement

Section I. Definitions of Terms Used in This Group Service Agreement

The following definitions will help you in understanding the terms that are used in this Group Service Agreement. As you are reading this Group Service Agreement you can refer back to this section. We have identified defined terms throughout the Agreement by capitalizing the first letter of the term.

Agreement

This Agreement, the Face Sheet, the schedule of Copayments, any optional Riders, any other attachments, your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

Contract Year

The 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

The amount shown in the schedule of Copayments that you pay at the time that certain covered Services and Supplies are delivered. You are responsible for paying the Copayment at the time services are received. Covered Services and Supplies means the actual billed charges, except when the Participating Provider has contracted with the Healthplan to receive payment on a basis other than fee-for-service amount, the charge will be calculated based on a healthplan-determined percentage of actual billed charges.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in

“Section II. Enrollment and Effective Date of Coverage” to be eligible to enroll as a Dependent.

Emergency Services

Emergency Services are defined in “Section IV. Covered Services and Supplies.”

Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

Healthplan

The CIGNA HealthCare health maintenance organization (HMO) which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as “we”, “us” or “our”.

Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his designee.

Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.



I. Definitions of Terms Used In this Group Service Agreement

Medically Necessary/Medical Necessity

Medically necessary covered Services and Supplies are those Services and Supplies that are determined by the Healthplan Medical Director to be:

- required to meet your essential health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the convenience of the Provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care; and

Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as “you” or “your”.

Membership Unit

The unit of Members made up of the Subscriber and his Dependent(s).

Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year.

Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide services to Members. Other Participating Health Professionals include, but are not limited to physical therapists, home health aides and nurses.

Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for you to receive the Services and Supplies covered by this Agreement.

Primary Care Physician (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him as your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for you.



I. Definitions of Terms Used In this Group Service Agreement

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Services and Supplies to be covered under this Agreement.

Referral

The approval you must receive from your PCP in order for the services of a Participating Provider, other than the PCP, or participating OB/GYN, or chiropractic Physician to be covered.

Rider

An addendum to this Agreement between the Group and the Healthplan.

Schedule of Copayments

The section of this Agreement that identifies applicable Copayments and maximums.

Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services.

Services and Supplies

Those Medically Necessary Services and Supplies described in "Section IV. Covered Services and Supplies."

Subscriber

An employee, or participant in the Group who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

Total Copayment Maximum

The total amount of Copayments that an individual Member or Membership unit must pay within a Contract Year. When the individual Member or Membership unit has paid applicable Copayments

up to the Total Copayment maximums, that Member or Membership unit will not be required to pay Copayments for those Services and Supplies for the remainder of the Contract Year. The Total Copayment maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Urgent Care

Urgent Care is defined in "Section IV. Covered Services and Supplies."

We/Us/Our

CIGNA HealthCare of Arizona, Inc.

You/Your

The Subscriber and/or any of his Dependents.

GSA-DEF(01)

Maricopa County
07/02



II. Enrollment and Effective Date of Coverage

Section II. Enrollment and Effective Date of Coverage

Who Can Enroll as a Member

To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

A. To be eligible to enroll as a Subscriber, you must:

1. be an employee of the Group or a participant in the Group; and
2. reside or work in the Service Area; and
3. meet and continue to meet these criteria.

B. To be eligible to enroll as a Dependent, you must:

1. be the legal spouse of the Subscriber; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, or the child legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
 - a. is unmarried and legally dependent upon the Subscriber for support;
 - i. has not yet reached age nineteen (19); or
 - ii. if the child is a full-time registered student in regular attendance at a secondary school, college or university or is a church missionary, has not yet reached age twenty-five (25). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and Urgent Care benefits while at school; or
 - iii. the child is nineteen (19) or older and continuously incapable of self-sustaining support because of

mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age [with respect to a student prior to attaining age twenty-five (25)]. You must submit proof of the child's condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

A Subscriber's grandchild is not eligible for coverage unless the grandchild meets the eligibility criteria for a Dependent.

NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" section.

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Maricopa County
01/03

Enrollment and Effective Date of Coverage

A. Enrollment during an Open Enrollment Period

If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within sixty (60) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional



II. Enrollment and Effective Date of Coverage

fees due, to the Group. If so enrolled, your effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the sixty (60) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. A newborn child who is born while this Agreement is being paid for at OTHER than a single or two-party rate shall have coverage effective as of the date of birth. While not a pre-condition to such coverage, it is strongly recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the newborn child prior to the birth of the child or within thirty-one (31) days after birth to assist in the administration of the health care plan. Failure to inform the Healthplan of the birth of a child may result in a delay in the appropriate processing of claims for services.

A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth, the Subscriber submits to the Healthplan through the Group an enrollment application and pays the additional Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within 31 days of the date you are granted legal guardianship. A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at other than a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber. While not a pre-condition to such coverage, it is strongly

recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the adopted child within thirty-one (31) days after the date of placement to assist in the administration of the health care plan. Failure to inform the Healthplan of the adoption of a child may result in a delay in the appropriate processing of claims for services. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed.

A child who is legally adopted by or is placed with the Subscriber for adoption by or is placed with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to the Healthplan through the Group an enrollment application and the Group pays any additional Prepayment Fees due. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or section 8-108 have been completed. If these requirements are not met but the adoption is later completed, the adopted child may be enrolled during the designated Open Enrollment Period. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay the Healthplan for all services and benefits provided to the child at prevailing rates for staff model services and at the contracted rates for other services.

C. Special Enrollment After Open Enrollment Period

There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may



II. Enrollment and Effective Date of Coverage

be eligible to enroll himself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:

1. Marriage;
2. Birth of a dependent newborn child; or
3. Adoption of a dependent child or legal placement of a child for adoption.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

D. Enrollment Due to Loss of Prior Creditable Coverage

If you and/or your Dependent(s) did not enroll as a Member during the Open Enrollment Period because you and/or your Dependent(s) had other creditable health care coverage, you may be eligible to enroll for coverage under this plan if you later lose that coverage. You must submit to the Group an Enrollment Application, and any applicable fees due within thirty-one (31) days of the day that you or your Dependent(s):

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
3. completed continuation of other coverage as provided under federal or state law.

If so enrolled, the effective date of coverage will be the first day of the month following the day on which the Healthplan received the Enrollment Application.

If these conditions are not met, or if you do not submit an Enrollment Application within thirty-one (31) days of one of these events, the next opportunity for you and any eligible

Dependent(s) to enroll will be during the next Open Enrollment Period.

E. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception.

F. Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the effective date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you become a Member of the Healthplan, you agree to permit the Healthplan to assume direct coordination of your health care. We reserve the right to transfer you to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with your attending Physician, determines that it is medically safe to do so.

If you are hospitalized on the effective date of coverage and you fail to notify us of this hospitalization, refuse to permit us to coordinate your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or hospital expenses that are related to your hospitalization following the first two (2) days after your coverage begins.

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Maricopa County
11/01



III. Agreement Provisions

Section III. Agreement Provisions

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your CIGNA HealthCare ID card or visit the CIGNA HealthCare web site at www.cigna.com.
2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any CIGNA company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self-Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.
6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating

Physician is often referred to as an "inpatient manager" or "hospitalist."

7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and the Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, the Group reserves the right to discontinue offering any plan of coverage.

8. Choosing a Primary Care Physician

When you enroll as a Member, you must choose a Primary Care Physician (PCP). Each covered Member of your family must also choose a PCP. If you do not select a PCP, we will assign one for you. If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them,



III. Agreement Provisions

and then verify the information with the PCP before making your selection.

9. Referrals to Specialists

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that you may make to a provider within a specified period of time. If you receive treatment from a provider other than your PCP without a Referral from your PCP, the treatment is not covered.

Exceptions to the Referral process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," without a Referral from your PCP.

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but you should, whenever possible, contact your PCP for direction prior to receiving services.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than your PCP when all of the following conditions apply:

1. You are a covered member of the Healthplan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with network specialist determines that your care requires another provider's expertise;
4. Your PCP determines that your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by your PCP to a network specialist who will be responsible for providing and coordinating your specialty care; and
6. The network specialist is authorized by the Healthplan to provide the services under the standing referral.

We may limit the number of visits and time period for which you may receive a standing referral. If you receive a standing referral or any other referral from your PCP, that referral remains in effect even if the PCP leaves the Healthplan's network. If the treating specialist leaves the Healthplan's network or you cease to be a covered member, the standing referral expires.

10. Choosing a Primary Care Physician

When you enroll as a Member, you may choose a Primary Care Physician (PCP) to be your personal doctor and serve as your health care manager. If you select a PCP his name will appear on your ID card. You may directly contact any PCP or other Participating Physician listed in the provider directory for your Service Area. You do not need a referral.

If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. You may also select a PCP at any time, if you did not select a PCP when you enrolled. We reserve the right to determine the number of times during a Contract Year that you will be



III. Agreement Provisions

allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

11. Transition Care

There may be instances in which your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, you will be notified and provided assistance in selecting a new PCP.

However, in special circumstances, you may be able to continue seeing your doctor, even though he or she is no longer affiliated with the Healthplan. If you are a new Member, upon written request to the Healthplan, you may continue an active course of treatment with your current health care provider during a transitional period after the effective date of enrollment if both of the following apply:

1. You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;
2. Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the non-participating provider for up to thirty (30) days. You may also be eligible to receive transitional care if you are in your second trimester of pregnancy. In this case, transitional care may continue through your

delivery and post-partum care. Such transitional care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his license to practice or retires.

If you are a new Member whose health care provider is not a member of the Healthplan's network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered your second trimester or pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

12. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your provider how he is compensated by us. The methods we use to compensate Participating Providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.



III. Agreement Provisions

Capitation – Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a “capitated” basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine

who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

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B. Member’s Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider’s education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it’s required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.



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6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP or another Participating Physician. Your doctor will give you advice, but you will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about us and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our appeals process if you do not agree with our decision.
10. Make recommendations regarding our policies on Member rights and responsibilities. If you have recommendations, please contact Member Services at the toll-free number on your CIGNA HealthCare ID card.

Your role is to:

1. Review and understand the information you receive about your health care plan. Please call CIGNA HealthCare Member Services when you have questions or concerns.
2. Understand how to obtain covered Services and Supplies that are provided under your plan.
3. Show your CIGNA HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new CIGNA HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don't understand; and follow your doctor's advice. You should also understand that your condition may not improve and may even

get worse if you don't follow your doctor's advice.

5. Understand your health condition and work with your doctor to develop treatment goals that you both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for you.
7. Know what medicine you take, why, and how to take it.
8. Pay all Copayments for which you are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by your plan.
11. Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.
12. Notify your employer as soon as possible about any changes in family size, address, phone number or membership status.

You represent that:

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
3. By presenting your CIGNA HealthCare ID card and receiving treatment and services from our Participating Providers, you authorize the following to the extent allowed by law:
 - a. any provider to provide us with information and copies of any records related to your condition and treatment;
 - b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any



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other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;

- c. us to disclose confidential information to any persons, company or entity to the extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Services and Supplies, or reporting to third parties involved in plan administration; and
- d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

This authorization will remain in effect until you send us a written notice revoking it or for such shorter period as required by law. Until revoked, we and other parties may rely upon this authorization.

With respect to Members, confidential information includes any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

- 4. You will not seek treatment as a CIGNA HealthCare Member once your eligibility for coverage under this Agreement has ceased.

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C. When You Have a Complaint or an Appeal

(For the purposes of this section, any reference to “you”, “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the care you receive. That’s why we’ve established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain

information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet (“Appeal Packet”). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your CIGNA HealthCare ID card or Benefit Identification card.

Start with Member Services

We’re here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

Appeals Processor Appeals Unit
CIGNA HealthCare National Appeals Unit
400 N. Brand Blvd.
Glendale, CA 91203

Customer Services Toll-Free Number that
appears on your CIGNA HealthCare ID card or
Benefit Identification card

We’ll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we’ll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

HEALTHPLAN has a three step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within two (2) years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.



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Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five (5) business days after receiving your request for review, the Healthplan will mail you and your Primary Care Physician (“PCP”) or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one (1) business day or seventy-two (72) hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, you must submit a request for the appeal in writing to the following address:

Appeals Processor Appeals Unit
CIGNA HealthCare National Appeals Unit
400 N. Brand Blvd.
Glendale, CA 91203

Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two (2) years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven’t already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving Medical Necessity or clinical appropriateness the committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 5 business days after receiving your request and schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within fifteen (15) calendar days and for post-service claims, the committee review and written notification of the Appeals Committee’s decision will be completed within thirty (30) calendar days. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed by the Appeals Committee to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the



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requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

After completing the Level One appeal process the Healthplan has the option to send your appeal directly to External Independent Review without making a decision at the Level Two appeal process.

External Independent Review

1. Eligibility

Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level 1 Appeal, and Level 2 Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from the Healthplan that your Level 2 Appeal has been denied, you have thirty (30) calendar days to submit a written request to the Healthplan for External Independent Review, including any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

(1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:

- mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
- Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

(2) Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within 5 business days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that the Healthplan should provide the service or pay the claim, the Healthplan must then authorize the service or pay the claim. If the IRO agrees with the Healthplan's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe



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the requested service is not covered under your evidence of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service or benefits coverage or a denied claim:

- (1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:
 - mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
 - send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- (2) Within fifteen (15) business days of the Director's receipt of your request for External Independent Review from the Healthplan, the Director of Insurance will:
 - determine whether the service or claim is covered, and
 - mail the decision to the Healthplan. If the Director decides that we should provide the service or pay the claim, we must do so.
- (3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision

and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

- (4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.
- (5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Insurance Director's final decision, the Healthplan may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision. OAH will schedule and complete a hearing for appeals from standard external independent review coverage decisions.

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from the Healthplan that your Expedited Level 2 Appeal has been denied, you have only 5 business days to submit a written request to the Healthplan for an Expedited External Independent Review. Your request should include any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.



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a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

- (1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:
 - mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
 - forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- (2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.
- (3) Within 5 business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

- (1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:
 - mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
 - forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- (2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Healthplan.
- (3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to the Healthplan, you and your treating provider.
- (4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent



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reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.

- (5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Director's final decision, the Healthplan may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to the Healthplan at least thirty (30) days before filing the suit stating your intention to file suit and the basis for your suit. You must include in your notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts,
date(s) of treatment or request)

Notice will be considered provided by you on the date received by the Healthplan. The notice of intent to file suit must be sent to the Healthplan via Certified Mail Return Receipt Request to the following address:

Attention: National Appeals Unit Director
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
400 N. Brand Blvd.
Glendale, CA 91203

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly

addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and the Healthplan as described above.

Appeal to the State of Arizona

If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602.912.8444 or 1.800.325.2548

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include (items 3, 4, and 5 are only included for adverse determinations): (1) the specific reason or reasons for the determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to



contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against HEALTHPLAN until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.



IV. Covered Services and Supplies

Section IV. Covered Services And Supplies

The covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments or limits are identified in the Schedule of Copayments.

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Services and Supplies are available to Members only if:

- They are medically necessary and not specifically excluded in this Section or in Section V.
- Provided by your Primary Care Physician (PCP) or if your PCP has given you a Referral, by another Participating Provider. However, “Emergency Services” do not require a Referral from your PCP and do not have to be provided by Participating Providers. Also, you do not need a Referral from your PCP for “Urgent Care”, and any services covered under this Agreement which are provided by a Participating Obstetrician/Gynecologist.
- Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services.

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care

and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

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Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for relief of acute pain, for the initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a



IV. Covered Services and Supplies

serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations is covered without prior authorization.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Healthplan.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the CIGNA HealthCare 24 Hour Health Information LineSM or your PCP for direction and authorization prior to receiving services.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Healthplan Medical Director in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of the Healthplan Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Agreement, and shall be reimbursed at the prevailing rate for self-pay patients in the area where the services were provided.

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Ambulance Service

Ambulance services to the nearest appropriate provider or facility. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- surgical services for reconstruction of the breast on which the mastectomy was performed;



IV. Covered Services and Supplies

- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Cancer Clinical Trials

Coverage shall be provided for medically necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.
2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Healthplan's network.
6. There is no clearly superior, non-investigational treatment alternative.
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

For the purposes of this specific covered Service and Benefit the following have the following meaning:

1. "Cooperative Group" – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. "Institutional Review Board" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit;



IV. Covered Services and Supplies

and (b) approved by the National Institutes of Health Office for Protection From Research Risks.

3. “Multiple Project Assurance Contract” – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
4. “Patient Cost” – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member’s contract; and (f) of treatment or services provided outside the State of Arizona.

Diabetic Service and Supplies

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes: Test strips for glucose monitors and visual reading and urine testing strips; insulin preparations; glucagon; insulin cartridges and insulin cartridges for the legally blind; syringes and lancets (including automatic lancing devices); oral agents for controlling blood sugar that are included on the Formulary; blood glucose monitors and blood glucose monitors for the legally blind; and injection aids; to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes; and any other device, medication, equipment or supply for which coverage is required under Medicare.

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Durable Medical Equipment

Purchase or rental of durable medical equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the

Healthplan for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a member's misuse are the member's responsibility.

Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines. Durable Medical Equipment items that are not covered, include but are not limited to those that are listed below.

- **Bed related items:** bed trays, over the bed tables, bed wedge, custom bedroom equipment, non-power mattress, pillows, posturpedic mattresses, low air loss mattresses (powered), alternating pressure mattresses.
- **Bath related items:** Bath lifts, non-portable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held shower, paraffin baths, bath mats, spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts-customizations).
- **Air quality items:** room humidifiers, vaporizers, air purifiers, electrostatic machines.
- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- **Pumps:** back packs for portable pumps.
- **Other equipment:** heat lamp, heating pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators,



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saunas, exercise equipment, diathermy machines.

Erectile Dysfunction

Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as post-operative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

External Prosthetic Appliances

The initial purchase and fitting of external prosthetic devices ordered or prescribed by a Participating Physician which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic devices shall include;

- Hearing aids;
- Basic limb prosthetics;
- Terminal devices such as a hand or hook;
- Braces and splints;
- Non-foot orthoses - only the following non-foot orthoses are covered:
 - a. Rigid and semi-rigid custom fabricated orthoses,
 - b. Semi-rigid pre-fabricated and flexible orthoses; and
 - c. Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthotics - custom orthotics are only covered as follows:
 - a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
 - b. When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace.

- c. When the foot orthotic is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect.
- d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positions of the foot and there is reasonable expectation of improvement.

The following are specifically excluded:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for replacement and repair of external prosthetic appliances is provided only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

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Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Home Health Services

Home health services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a hospital or Other Participating Health Care Facility.



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Home health services are provided only if the Healthplan Medical Director has determined that the home is a medically appropriate and cost-effective setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home health services are those skilled health care services that can be provided during intermittent visits of two (2) hours or less by Other Participating Health Professionals. Necessary consumable medical supplies, home infusion therapy, and durable medical equipment administered or used by Other Participating Health Professionals in providing home health services are covered. Home health services do not include services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

Hospice Services

Hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Physician as having a terminal illness with a prognosis of six months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

- services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- services and supplies for curative or life-prolonging procedures;
- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your dependent in daily living;

- services and supplies for respite (custodial) care; and
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a participating skilled nursing facility or a similar institution; a participating home health care agency; a participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Healthplan; and fulfills all licensing requirements of the state or locality in which it operates.

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Infertility Services

Services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

- infertility drugs;
- in vitro fertilization; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
- reversal of voluntary sterilization;



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- infertility services when the infertility is caused by or related to voluntary sterilization;
- cryopreservation of donor sperm and eggs; and
- any experimental or investigational infertility procedures or therapies.

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Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles. Medically necessary repair, maintenance or replacement of a covered appliance is covered.

Laboratory and Radiology Services

Radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms

Mammograms for routine and diagnostic breast cancer screening as follows: a single baseline mammogram if you are age 35-39; once per every other Contract Year if you are age 40-49, or more frequently based on the recommendation of your PCP; and once per Contract Year if you are age 50 and older.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a

minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These maternity care benefits also apply to the natural mother of a newborn child legally adopted by you in accordance with the Healthplan adoption policies. and Arizona law.

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Substance Abuse Services

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Healthplan Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Substance Abuse Services

The following are specifically excluded from substance abuse services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this agreement;
- Counseling for occupational problems;
- Residential treatment;
- Custodial care.

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Medical Foods

Medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food



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coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

We will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract. There is a maximum annual limit for medical foods of \$5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

For the purpose of this section, the following definitions apply:

1. "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
2. "Medical Foods" means modified low protein foods and metabolic formula.
3. "Metabolic Formula" mean foods that are all of the following: (a) formulated to be consumed or administered externally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
4. "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered externally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that

is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostasis.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider when diet is a part of the medical management of a documented organic disease, including clinically severe morbid obesity.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services and Supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Organ Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.

All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified or provisional CIGNA Lifesource Organ Transplant Network® facility.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ



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removal, organ transportation and the transportation, hospitalization and surgery of a live donor.

Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ Transplant Travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA Lifesource Organ Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- lodging while at, or traveling to and from the transplant site; and
- food while at, or traveling to and from the transplant site.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Oxygen

Oxygen and the oxygen delivery system. However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Periodic Health Examinations

Periodic Health Examinations, include vision and hearing screenings provided by Primary Care Physician and are available on at least the following schedule:

Age	0-1 year	1 exam every 4 months
Age	2-5 years	1 exam every year
Age	6-40 years	1 exam every 5 years
Age	41-50 years	1 exam every 3 years
Age	51-60 years	1 exam every 2 years
Age	61 and over	1 exam every year

Additionally, Periodic Health Examinations are available to each Member within twelve (12) months after their coverage is effective.

Reconstructive Surgery

Reconstructive surgery or therapy that constitutes necessary care and treatment for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption who were covered from birth, adoption or adoption placement. Additionally, reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw or related to TMJ disorder) provide that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or
- reconstruction is required as a result of medically necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital



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absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

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Short-term Rehabilitative Therapy and Chiropractic Care Services

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to short-term rehabilitative therapy:

- Services which are considered custodial or educational in nature are not covered.
- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living.
- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed in children due to an underlying disease or malformation that prevented speech development; (b) intended to maintain speech communication; or (c) not restorative in nature.

If multiple services are provided on the same day they constitute one visit, but a separate Copayment will apply to each Participating Provider.

Services that are provided by a chiropractic Physician are not covered under this section. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians and Osteopaths. Chiropractic treatment

includes the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified participating chiropractic Physicians and Osteopaths; you do not need a Referral from your PCP.

The following are specifically excluded from chiropractic care and osteopathic services:

- Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent reoccurrence or to maintain the patient's current status; and
- Vitamin therapy.

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Vision and Hearing Screenings for Dependents

Vision and hearing screenings provided by your PCP are made available to you as described in the "Periodic Health Examination" schedule in this section.

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Section V. Exclusions And Limitations

Exclusions

Any Services and Supplies which are not described as covered in "Section IV. Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV. Covered Services and Supplies" or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
5. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
6. Any Services and Supplies which are experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be:

 - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means
 - scientific studies published in a peer-reviewed national professional medical journal;
 - the subject of review or approval by an Institutional Review Board for the proposed use;
 - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight, except as set forth in the "Cancer Clinical Trials" provision of "Section IV. Covered Services and Supplies"; or
 - not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
7. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is medically necessary.
8. Orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary treatment of TMJ disorder is covered.
9. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are



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- covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
10. Medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, and jejunal bypass.
 11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
 12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
 13. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
 14. Reversal of voluntary sterilization procedures.
 15. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 16. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
 17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
 18. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
 19. Therapy to improve general physical condition including, but not limited to, routine, long term or nonmedically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.
 20. Consumable medical supplies, other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
 21. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the Healthplan Medical Director.
 22. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
 23. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the "Diabetic Services and Supplies" provision of the "Covered Service and Supplies" section of the Agreement.
 24. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery).
 25. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 26. Treatment by acupuncture.
 27. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
 28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.



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29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
30. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
31. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Healthplan Medical Director for the purpose of making treatment decisions.
32. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
33. Blood administration for the purpose of general improvement in physical condition.
34. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
35. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for:
 - The treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
 - enteral feeding for which the nutritional formulae (a) under state or federal law can be dispensed only through a physician's prescription and (b) is medically necessary as the primary source of nutrition..
36. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

Limitations

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil

insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

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VI. Other Sources of Payment For Services and Supplies

Section VI. Other Sources of Payment for Services and Supplies

Workers' Compensation

Benefits under this Agreement will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Healthplan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement, the Healthplan shall have the right to receive reimbursement either (1.) directly from the entity which provides Member's workers' compensation coverage; or (2.) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where the Healthplan has directly rendered or arranged for the rendering of services the Healthplan shall have a right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where the Healthplan does not render services but pays for those services which are within the scope of the "Covered Services and Supplies" section of the Agreement. The healthplan shall have a right of reimbursement to the extent that the Healthplan has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by the Healthplan to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure to the employer to take the steps required by law or regulation in connection with such coverage.

Medicare Benefits

Except as otherwise provided by federal law, the services and benefits under this Agreement for Members age sixty-five (65) and older, or for Members otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Members are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Members are payable to and shall be retained by the Healthplan. Members enrolled in Medicare shall cooperate with and assist the

Healthplan in its efforts to obtain reimbursement from Medicare or the Member in such instances.

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Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies;
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.



VI. Other Sources of Payment For Services and Supplies

Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definitions of an Allowable Expense.

Claim Determination Period

A calendar year, but it does not include any part of a year during which you are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;
3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - b. Then, the Plan of the parent with custody of the child;
 - c. Then, the Plan of the spouse of the parent with custody of the child;
 - d. Then, the Plan of the parent not having custody of the child, and
 - e. Finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the Plans that covers you is issued out of the state whose laws govern this Agreement and determines the order of benefits based upon the gender of a parent,



VI. Other Sources of Payment For Services and Supplies

and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefit payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for you. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As to each claim that is submitted, we shall determine the following:

1. Our obligation to provide Services and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for you to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the Primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information.

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

F. Injuries Covered under Med Pay Insurance

If you are injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Healthplan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses. The Healthplan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments. Payment for such services and benefits shall be your responsibility. If the Healthplan paid in excess of their obligation, you may be asked to assist the Healthplan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating your injuries.

G. Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable Copayment or other amount you are obligated to pay under this Agreement for covered services. However, Arizona law also entitles certain Participating Providers to assert a lien for their customary charges for the care



VI. Other Sources of Payment For Services and Supplies

and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Provider has received from Healthplan as payment for covered services, and (2) the Participating Provider's full billed charges.



VII. Termination of Your Coverage

Section VII. Termination of Your Coverage

We may terminate your coverage for any of the reasons stated below.

Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in “Section II. Enrollment and Effective Date of Coverage” as either a Subscriber or Dependent, your coverage under this Agreement shall cease. Coverage of all Members within a Membership Unit shall cease when the Subscriber fails to meet the eligibility criteria. The Group shall notify us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide Services and Supplies.

Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. **Termination for Non-Payment of Fees.** We may terminate this Agreement for the Group’s non-payment of any Prepayment Fees owed to us.
2. **Termination on Notice.** The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. **Termination for Fraud or Misrepresentation.** We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the

Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.

4. **Termination for Violation of Contribution or Participation Rules.** We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. **Termination Due to Association Membership Ceasing.** If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for any reason by CIGNA, and is not replaced by any other health coverage, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under "Continuation of coverage" section.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to you prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.



VII. Termination of Your Coverage

Certification of Creditable Coverage Upon Termination

We will issue you a Certification of Group Health Plan Creditable Coverage as required by law and based on information provided to us by the Group at the following times:

1. When your coverage is terminated for cause or by reason of ineligibility or you otherwise become covered under “Section VIII. Continuation of Coverage”;
2. When your continuation coverage, if you elected to receive it, is exhausted; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations.



VIII. Continuation of Coverage

Section VIII. Continuation of Coverage

Continuation of Group Coverage under COBRA

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), an employer must give its employees and dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required premiums are paid when due and will be subject to future plan changes.

A **qualifying event** is any of the following:

- termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan; or
- if the plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within one year before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within 60 days after the date of such qualifying. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued health care is not automatic.

Continuation of COBRA benefits must be elected within 60 days of the later of the following:

- the date the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- the date the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

The Subscriber or eligible Dependent may be required to pay a premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be due on a monthly basis. There is a 30 day grace period to pay premiums. If the premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is 18 months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this 18 month period, the period of coverage for any affected Dependent may be extended to up to 36 months from the date of the initial qualifying event.

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first 60 days of continued coverage, the 18 month period may be extended to up to 29 months. If there are non-disabled family members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.



VIII. Continuation of Coverage

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then

- the Subscriber may continue the group health coverage for up to 18 months from the date of termination or reduction in hours worked, and
- any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) 36 months from the date the Subscriber first became entitled to Medicare, or (ii) 18 months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- the date of death of the retired Subscriber; or
- for a surviving spouse or eligible Dependent, 36 months after the date of death of the retired employee.

For all other qualifying events, the maximum period is 36 months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the 18, 29 or 36 month period.

Other events will cause COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the employer ceases to provide any group health plan to any employee;
- the date the Subscriber or eligible Dependent fails to timely pay any required premium payment;

- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of the maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain COBRA coverage to the expiration date.

IMPORTANT NOTICE - COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

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Conversion to Non-Group (Individual) Coverage

If you do not elect COBRA continuation coverage, fail to properly elect COBRA continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA continuation coverage for which the maximum coverage period has expired, you may apply to the Healthplan for conversion to non-group (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:



VIII. Continuation of Coverage

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the “Termination of Agreement” provisions of “Section VII. Termination of Your Coverage,” you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Prepayment Fee within thirty-one (31) days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) days of the loss of group coverage your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If you are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If you are a Dependent who has lost eligibility for coverage under this Agreement due to your attainment of an age limitation identified in the Agreement, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

D. Conversion After Expiration of COBRA Continuation Coverage

A Member whose COBRA continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The Services and Supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall

be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the Services and Supplies provided under this Agreement.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as the Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

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**Section IX. Miscellaneous****Additional Programs**

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

- Health Club/GYM Memberships
- Tai-Chi Classes
- Weight Loss Program
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes-Selected classes may be offered to our Members for a copayment at participating CIGNA HealthCare Centers
- CIGNA HealthCare Healthy Babies Program®

These programs are provided for the benefit of CIGNA HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty (60) days' prior notice.

Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. The Healthplan may, at its option, make payment to the Subscriber for any cost of any covered Services and Supplies received by the Subscriber or Subscriber's covered dependents from a non-participating provider. The Subscriber is responsible for reimbursing the non-participating provider.

Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through United States Postal Service to the addresses set forth on the Cover Sheet.

Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.



Service Marks

The CIGNA HealthCare 24 Hour Health Information LineSM and CIGNA Lifesource Organ Transplant Network® are registered service marks of CIGNA Corporation.

Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

**Schedule of Copayments**

THIS SCHEDULE OF COPAYMENTS IS A SUPPLEMENT TO THE GROUP SERVICE AGREEMENT PROVIDED TO YOU AND IS NOT INTENDED AS A COMPLETE SUMMARY OF THE SERVICES AND SUPPLIES COVERED OR EXCLUDED.

It is recommended that you review your Group Service Agreement for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Covered Services and Supplies	Copayments
Physician Services Primary Care Physician Office Visit Preventive Care Adult Medical Care Periodic Physical Evaluation for Adults Well-Child Care Routine Immunizations and Injections Surgery Performed in the Physician's Office Specialty Care Physician Office Visit Office Visits Surgery Performed in the Physician's Office	\$25 Copayment per office visit The office visit Copayment will be waived when immunization is the only service provided \$45 Copayment per office visit
Inpatient Hospital Services Semi Private Room and Board Physician and Surgeon Charges Laboratory, Radiology and other Diagnostic and Therapeutic Services Administered Drugs, Medications, Biologicals and Fluids Special Care Units Operating Room, Recovery Room Anesthesia Inhalation Therapy Radiation Therapy and Chemotherapy	\$500 and 10% Copayment per admission
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, and Treatment Room including Physician Services Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy	\$250 and 10% Copayment per facility use



Schedule of Copayments

Covered Services and Supplies	Copayments
Emergency and Urgent Care Services	
Physician's Office	Same as Physician Office Visit Copayment
Hospital Emergency Room or Outpatient Facility	<p>\$100 Copayment per visit</p> <p>The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room</p>
Urgent Care Facility	\$50 Copayment per visit
Ambulance Services	No Charge
Diabetic Services and Supplies	
Self Management Courses and Training	Same as Physician Office Visit Copayment
Equipment	Same as Durable Medical Equipment Copayment per item
Insulin and other Diabetic Pharmaceutical Supplies	\$10 Copayment per item/per prescription
Durable Medical Equipment \$3,500 maximum per Member per Contract Year; except that Equipment related to the treatment of Diabetes is not subject to a dollar maximum.	No Charge
External Prosthetic Appliances \$200 deductible per Member per Contract Year. \$1,000 maximum per Member per Contract Year. Hearing Aids \$2,200 maximum every three contract years. The deductible does not apply.	No Charge after the deductible
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used



Schedule of Copayments

Covered Services and Supplies	Copayments
Home Health Services Maximum of 16 hours in total per day	No Charge
Hospice Services Inpatient Services Outpatient Services	No Charge No Charge
Infertility Services Physician Office Visit Surgical Treatment	Same as Physician Office Visit Copayment 50% Copayment per procedure
Inpatient Services at Other Participating Health Care Facilities 90 day maximum per Member per Contract Year Rehabilitation Hospital Skilled Nursing Facility and Sub-Acute Facilities	No Charge No Charge
Laboratory and Radiology Services Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans, etc.) Other Laboratory and Radiology Services	\$100 Copayment No Charge
Mammography	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
Maternity Care Services Initial Office Visit to Confirm Pregnancy All other Office Visits Delivery	Same as Physician Office Visit Copayment No Charge Same as Inpatient Hospital Copayment



Schedule of Copayments

Covered Services and Supplies	Copayments
Substance Abuse Services	
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copayment
Outpatient Substance Abuse Detoxification Therapy	Same as Physician Office Visit Copayment
Nutritional Evaluation 3 visit maximum per Member per Contract Year	Same as Physician's Office Visit Copayment
Transplant Travel Services Maximum \$10,000 maximum benefit	
Short-term Rehabilitative Therapy Services provided on an outpatient basis are limited to a 60 visit maximum per Member per Contract Year	\$45 Copayment per office visit
Chiropractic Care Services Services provided on an outpatient basis are limited to a 20 visit maximum per Member per Contract Year	\$45 Copayment per office visit
Total Copayment Maximum *	
Individual Member Total Copayment Maximum	\$5,000 per Contract Year
Membership Unit Total Copayment Maximum	\$10,000 per Contract Year



Schedule of Copayments

*Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital Services, Outpatient Facility Services, Inpatient Services at Other Participating Health Care Facilities, Inpatient Mental Health Services, Inpatient Substance Abuse Rehabilitation and Inpatient Detoxification Services apply to these maximums. It is the Member's responsibility to maintain a record of Copayments which have been paid, and to inform the Healthplan when the amount reaches the Total Copayment Maximum.

Note: If the Participating Provider has contracted with the Healthplan to receive payment on a basis other than fee-for-service amount, then your percent Copayment will be calculated based on a Healthplan-determined fee schedule amount or Healthplan-determined percentage of actual billed charges.

**Alternative Medical Services Benefit**

This Supplemental Rider is a part of the CIGNA HealthCare of Arizona, Inc. Group Service Agreement (the Agreement) and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment fee, the following supplemental benefit for Alternative Medical Services are added to the Agreement.

I. Definitions

- a. **Alternative Medical Services** means services, treatments or products not performed, practiced or provided within the practice of standard medicine.
- b. **Designated Alternative Medicine Center** means a facility or Physician qualified to provide certain Alternative Medical Services who is specifically designated by the HEALTHPLAN Medical Director to provide those services.

II. Services and Benefits

Coverage will be provided for certain outpatient Alternative Medical Services received from a Designated Alternative Medicine Center or other Participating Health Professional which are considered to be appropriate options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a Designated Alternative Medicine Center. Services for a Member may be authorized by a Participating Physician, or the Member may obtain the services from a Designated Alternative Medicine Center without authorization for up to ten (10) visits per Contract Year.

- a. Outpatient Alternative Medical Services. Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the HEALTHPLAN Medical Director.
- b. Herbal or Homeopathic Products. Herbal or homeopathic products which are approved by the HEALTHPLAN are covered when obtained at a Designated Alternative

Medical Center. The retail cost of these Products is subject to a Contract Year maximum of \$60.00.

Coverage provided under this Rider shall be subject to the following Copayments:

- Office Visit - \$5 Copayment per visit
- Herbal and Homeopathic Products - No Charge

III. Exclusions

Except as otherwise set forth in this Rider, coverage is subject to the exclusions and limitations set forth in the Exclusions and Limitations Section of the Agreement.

ALTMED-AZ

Maricopa 1/05



CIGNA HealthCare 24-Hour Health Information LineSM 1.800.564.8982

The Health Information Nurses

A specially trained team of registered nurses is on duty around the clock. Your nurse will ask you a few questions about your symptoms and situation, then direct you to the type of care that should make you more comfortable.

- If your condition doesn't require immediate care, your nurse will recommend steps you can take to be more comfortable until you see your doctor.
- If you're away from home, the nurses can help you locate nearby participating doctors, facilities and pharmacies.
- If you need urgent care, your nurse will direct you to the nearest qualified provider or facility and help you with any necessary authorizations.
- If it appears that you need emergency care, your nurse will direct you to call 911 or other emergency services in your area. Your nurse will help you access the appropriate services.
- If you're directed to seek immediate medical attention, we'll provide your primary care physician with the details. This information becomes part of your medical records, updates your health status and alert your doctor to the need for follow-up care.

The Health Information Library

You can listen to tapes on topics ranging from aging and women's health to nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can listen to as many tapes as you like, and this booklet includes a handy directory to hundreds of subjects.

It's simple to use, easy to understand

- Just call 1.800.564.8982.
- Follow the simple instructions that quickly guide you to the information you need. If you have a rotary-dial phone, stay on the line for assistance.
- Use this handy directory to enter the code numbers of the programs you'd like to hear.
- There's no limit to the number of programs you can request in a single call.

Nurses are always standing by

To speak with a Health Information Nurse at any time during your call - even if you're in the middle of a Health Information Library tape - our system will quickly and automatically connect you.

Call us if you're concerned or just curious

- Use the 24-Hour Health Information Line for helpful, everyday health information on all sorts of subjects, from sleeplessness to sunburn.
- You'll really appreciate this service if you have young children.
- If it's difficult for your primary care physician to call you back - if you're vacationing or traveling on business, if you're retired and travel often, or if you have kids away at school - the Health Information Line is a valuable first step in learning about and caring for everyday health matters.

Don't wait, don't wonder, or possibly delay necessary treatment or helpful self-care. Call the CIGNA HealthCare 24-Hour Health Information LineSM and get the information you need. Quickly and easily.



Health Information Library

1.800.564.8982

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- 3001 Abuse of Older Adults
- 3002 Adult Day Care Programs
- 3003 Advance Directives
- 3004 Alcohol and Aging
- 3005 Alzheimer's Disease
- 3006 Caregiver's Guide
- 3007 Constipation
- 3008 Dementia
- 3009 Dental Care for Older Adults
- 3010 Depression in Older Adults
- 3011 Elderhostel and Adult Education
- 3012 Erectile Dysfunction (Impotence)
- 3013 Exercise for Older Adults
- 3014 Fluid Requirements of Older Adult
- 3015 Health Benefits for Veterans
- 3016 Health Changes With Aging
- 3017 Home Healthcare
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- 3019 How to Choose a Nursing Home
- 3020 Hypothermia in Older Adults
- 3021 Insomnia in Older Adults
- 3022 Loneliness in Older Adults
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- 3025 Medicare: Health Insurance
- 3026 Medicines: Problems They Can Cause
- 3027 Nutrition for the Later Years
- 3028 Pets Benefit the Older Adult
- 3029 Retirement Planning
- 3030 Preventing a Broken Hip
- 3031 Medicines: Using Them Safely
- 3032 Self-Esteem in Older Adults
- 3033 Senior Centers
- 3034 Sexuality in the Later Years
- 3035 Skin Care and Protection
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- 3102 Allergy Proof Your Home
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- 3104 Allergy Treatment
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- 3108 Eczema
- 3109 Food Allergy
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- 3301 Abuse and Violence - Adults
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- 3303 Agoraphobia
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- 3305 Alcoholism: Information and Resources
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- 3308 Anorexia Nervosa
- 3309 Antisocial Personality Disorder
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- 3313 Binge Eating Disorder (Compulsive Overeating)
- 3314 Bipolar Disorder (Manic-Depressive Illness)
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- 3336 Kleptomania
- 3337 Letting Go of Resentment
- 3338 Lying: Pathologic
- 3339 Masochism
- 3340 Mental Health Professionals
- 3341 Multiple Personality (Dissociative Identity Disorder)
- 3342 Narcissism (Narcissistic Personality Disorder)
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- 3344 Nightmares and Sleep Terrors
- 3345 Obsessive-Compulsive Disorder (OCD)
- 3346 Panic Attacks (Panic Disorder)
- 3347 Paranoid Personality Disorder
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- 3158 Artificial Limb
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- 3160 Athlete's Foot
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4600 Enlarged Prostate (Benign Prostatic Hyperplasia)

4601 Erectile Dysfunction (Impotence)

4602 Hair Loss

4603 Infertility

4604 Male Condom

4605 Penile Inflammation

4606 Premature Ejaculation

4607 Prostate Problems

4608 Prostatectomy

4609 Routine Healthcare for Men

4610 Sexual Response in Men

4611 Testicular Self-Examination

4612 Vasectomy

Nutrition and Weight Control

4700 Caffeine in Your Diet

4701 Calcium

4702 Carbohydrates

4703 Dealing with Feelings About Food

4704 Diabetes: Food Management

4705 Dieting and Eating Out

4706 Eating Basics for Children

4707 Eating Healthy Snacks

4708 Exercise to Stay Healthy

4709 Fat in Your Diet

4710 Fat-Free Foods

4711 Fiber in Your Diet

4712 Grains in the Diet

4713 Healthy Weight Gain

4714 Losing Weight

4715 Nutrition for Diabetics: Eating Out

4716 Nutrition for Diabetics: Food Labels

4717 Nutrition for Diabetics: Protein

4718 Nutrition for Diabetics: Use of Alcohol

4719 Obesity

4720 Overcoming Binge Eating

4721 Overweight Child

4722 Overweight or Overfat?

4723 Protein

4724 Reading Food Labels

4725 Salt in the Diet

4726 Sugar in Our Diets

4727 Sugar Substitutes

4728 The Healthy Diet

4729 Usda Food Guide Pyramid

4730 Food Diary Use

4731 Vegetarian Diet

4732 Vitamins

4733 Weight Loss Diets

Preventive Health

4650 Back Pain Prevention: Body Mechanics

4651 Bathroom Safety

4652 Cancer Prevention and Nutrition

4653 Childproofing Your Home

4654 Controlling Cholesterol

4655 Diet for a Healthy Mouth

4656 Drowning Prevention

4657 Exercise to Stay Healthy

4658 Exercises for the Workplace

4659 Personal Health Management

4660 Heart Disease: Prevention

4661 Home Safety Tips

4662 How Noise Affects Hearing

4663 Immunization Schedule: Children

4664 Immunizations: Adults

4665 Lift It Right

4666 Medicines: Using Them Safely

4667 Obesity

4668 Poison Prevention

4669 Preventing Burns and Scalds

4670 Preventing Falls

4671 Protecting Yourself from Cancer

4672 Routine Healthcare for Men

4673 Routine Healthcare for Women

4674 Safety Seats for Children

4675 Stress and Its Effects on the Body

4676 Water: Essential for Good Health

Respiratory Health

4800 Acute Bronchitis

4801 Asthma

4802 Breathing Exercises

4803 Bronchiolitis

4804 Bronchoscopy

4805 Chronic Bronchitis

4806 Chronic Obstructive Pulmonary Disease (COPD)

4807 Collapsed Lung: Injury-Related

4808 Collapsed Lung: Non-Injury-Related

4809 Cough

4810 Emphysema

4811 Pneumonia

4812 Pulmonary Embolism

4813 Pulmonary Function Tests

4814 Shortness of Breath

4815 Sleep Apnea

4816 Sleep Apnea: Infants

4817 Snoring

4818 Thoracentesis

4819 Using Oxygen at Home

Safety and Emergency Preparedness

4900 Animal and Human Bites

4901 Anthrax

4902 Bee Stings

4903 Biological Terrorism Agents

4904 Blisters

4905 Bruises

4906 Cardiopulmonary Resuscitation (CPR)

4907 Chemical Terrorism Agents

4908 Chemical Warning Labels

4909 Choking Prevention

4910 Dehydration

4911 Driving Responsibly

4912 Electrical Shock

4913 Electricity: Preventing Injuries

4914 Eye Symptoms Demanding Immediate Attention

4915 First Aid for First-Degree Burns

4916 First Aid for Second-Degree Burns

4917 First Aid for Third-Degree Burns

4918 Food Poisoning

4919 Food Poisoning: Botulism

4920 Food Poisoning: E. Coli Infection

4921 Food Poisoning: Salmonellosis

4922 Frostbite

4923 Heart Attack: Early Warning Signs

4924 Heat Illness

4925 Home First Aid Supplies

4926 Home Security

4927 Hypothermia

4928 Poisoning

4929 Puncture Wounds

4930 Rape

4931 Rape Prevention

4932 Rice: Rest, Ice, Compression, Elevation

4933 Safety Glasses and Goggles

4934 Scrapes and Scratches

4935 Smallpox Vaccine

4936 Snakebites

4937 Something in Your Eyes

4938 Sore Throat

4939 Spider Bites and Scorpion Stings

4940 Splinters

4941 Sunburn



- 4942 Tetanus Vaccine
4943 Tick Bites

Skin Health

- 4850 Acne
4851 Blisters
4852 Boils and Carbuncles
4853 Canker Sores
4854 Cellulitis
4855 Cold Sores (Fever Blisters)
4856 Contact Dermatitis
4857 Dandruff
4858 Eczema
4859 Hives
4860 Impetigo
4861 Itching
4862 Moles
4863 Plantar Warts
4864 Psoriasis
4865 Rosacea
4866 Seborrhea
4867 Sjogren's Syndrome
4868 Skin Infection
4869 Skin Lesions
4870 Skin or Soft Tissue Abscess
4871 Sunburn
4872 Tanning Beds
4873 Warts

Surgery

- 5000 Anesthesia
5001 Body Contouring
5002 Breast Enlargement (Augmentation Mammoplasty)
5003 Breast Reconstruction
5004 Breast Reduction (Reduction Mammoplasty)
5005 Eyelid Surgery (Blepharoplasty)
5006 Facelifts
5007 Laser Treatment
5008 Liposuction
5009 Nose Reconstruction (Rhinoplasty)
5010 Skin Resurfacing
5011 Tummy Tuck

Symptoms

- 5050 Abdominal Cramps
5051 Constipation
5052 Cough
5053 Dehydration
5054 Dizziness and Vertigo
5055 Earache
5057 Fever
5058 Heart Palpitations

- 5059 Heartburn
5060 Insomnia
5061 Irritability
5062 Loss of Appetite
5063 Lymph Nodes: Enlarged
5064 Memory Loss
5065 Nausea and Vomiting
5066 Nervousness
5067 Personality Change
5068 Rectal Bleeding
5069 Shortness of Breath
5070 Skin Lesions
5071 Swallowing Difficulty (Dysphagia)
5072 Tinnitus
5073 Urinary Incontinence
5074 Urination Problems
5075 Wheezing

Tests and Examinations

- 5100 Angiograms
5101 Arterial Blood Gases
5102 Barium Enema
5103 Barium X-Ray Exam: Esophagus and Stomach
5104 Biopsy
5105 Blood (Serum) Glucose Test
5106 Blood: Iron Test
5107 Bone Marrow Biopsy
5108 Bone Scan
5109 Bronchoscopy
5110 Cholesterol: Lipid Panel Test
5111 Colonoscopy
5112 Colorectal Cancer Screening
5113 Colposcopy of the Vagina and Cervix
5114 Complete Blood Count Test (CBC)
5115 Coronary Angiogram
5116 CT Scanning
5117 Cystoscopy
5118 Diagnostic Laparoscopy
5119 Echocardiogram
5120 Electrocardiogram (ECG or EKG)
5121 Electroencephalogram (EEG)
5122 Electromyogram (EMG)
5123 Endoscopic Retrograde Cholangiopancreatography (ERCP)
5124 Fluoroscopy
5125 Heart Catheterization
5126 Holter Monitors
5127 Magnetic Resonance Imaging (MRI)
5128 Mammograms
5129 Pap Smear (Cervical Smear)

- 5130 Percutaneous Transhepatic Cholangiography (PTHC)
5131 Sigmoidoscopy
5132 Thyroid Scan
5133 Thyroid-Stimulating Hormone (TSH) Test
5134 Thyroxine (T4) Test
5135 Ultrasound Scanning
5136 Urine Culture
5137 Urine Tests
5138 X-Rays

Urinary and Genital Systems

- 5350 Acute Kidney Failure (Acute Renal Insufficiency)
5351 Bladder Infection (Cystitis)
5352 Blood in Urine (Hematuria)
5353 Chronic Kidney Failure (Chronic Renal Insufficiency)
5354 Functional Urinary Incontinence
5355 Indwelling Catheter Care
5356 Kegel Exercises for Bladder Control
5357 Kidney Infection (Pyelonephritis)
5358 Kidney Stones
5359 Lithotripsy for Kidney Stones
5360 Overflow Incontinence
5361 Urge Incontinence
5362 Urinary Catheterization
5363 Urinary Incontinence
5364 Urinary Obstruction
5365 Urinary Tract Infection in Men
5366 Urinary Tract Infection in Women

Women's Health

- 5200 Abdominal Hysterectomy
5201 Abuse and Violence - Adults
5202 Amniocentesis
5203 Atrophic Vaginitis
5204 Bartholin's Gland Cyst
5205 Benign Ovarian Tumor
5206 Birth Control
5207 Birth Control Patch
5208 Birth Control Pills
5209 Bleeding Between Menstrual Periods (Metrorrhagia)
5210 Breast Infection (Mastitis)
5211 Breast Self-Exam
5212 Cervical Cap
5213 Cervical Dysplasia
5214 Cervical Polyps
5215 Cervicitis
5216 Cesarean Section

- 5217 Choosing a Healthcare Provider for Your Pregnancy
5218 Chorionic Villus Sampling (CVS)
5219 D&C, Diagnostic (Dilation and Curettage)
5220 D&C, Therapeutic (Dilation and Curettage)
5221 Danger Signs in Pregnancy
5222 Depo-Provera
5223 Diabetes in Pregnancy
5224 Diaphragm
5225 Diet During Pregnancy
5226 Diethylstilbestrol (DES)
5227 Drug, Alcohol, and Tobacco Use During Pregnancy
5228 Ectopic Pregnancy
5229 Emergency Birth Control (Morning-After Pill)
5230 Endometrial Biopsy
5231 Endometriosis
5232 Episiotomy
5233 Exercise After Delivery
5234 Exercise During Pregnancy
5235 Female Condom
5236 Female Sterilization
5237 Feminine Hygiene
5238 Fetal Alcohol Syndrome
5239 Fibrocystic Breast Changes
5240 Genetic Screening Before or During Pregnancy
5241 Getting Ready for Pregnancy
5242 Hair Loss in Women
5243 Hot Flashes
5244 Hysteroscopy
5245 Infertility
5246 Intrauterine Device (IUD)
5247 Labor and Delivery
5248 Mammograms
5249 Menopausal Hormone Therapy
5250 Menopause
5251 Menstrual Cramps
5252 Miscarriage
5253 Missed Menstrual Periods (Amenorrhea)
5254 Morning Sickness
5255 Natural Family Planning
5256 Nipple Discharge (Galactorrhea)
5257 Normal Growth of a Baby During Pregnancy
5258 Norplant
5259 Ovarian Cysts
5260 Overcoming Fear of Childbirth
5261 Ovulation Abnormalities
5262 Painful Intercourse
5263 Pelvic Examination
5264 Pelvic Inflammatory Disease
5265 Pelvic Support Problems



5266 Postmenopausal Bleeding
5267 Postpartum Care
5268 Postpartum Complications
5269 Postpartum Depression
5270 Preeclampsia
5271 Pregnancy Tests
5272 Premenstrual Dysphoric
Disorder (PMDD)
5273 Premenstrual Syndrome
(PMS)
5274 Prenatal Care
5275 Prenatal Tests
5276 Routine Healthcare for
Women
5277 Ruptured Membranes
5278 Sex During Pregnancy
5279 Sexual Abstinence
5280 Sexual Response in Women
5281 Skin Conditions During
Pregnancy
5282 Smoking During Pregnancy
5283 Spermicides
5284 Stress Incontinence in Women
5285 Tipped Uterus
5286 Toxic Shock Syndrome
5287 Travel When You Are
Pregnant
5288 Uterine Fibroids
5289 Vaginal Contraceptive Ring
5290 Vaginal Cysts, Polyps, and
Warts
5291 Vaginal Hysterectomy
5292 Vaginal Hysterectomy with
Laparoscopy
5293 Vaginitis
5294 Vulvar Dystrophy
5295 Vulvitis
5296 Working During Pregnancy
5297 Yeast Infection (Candidiasis)